Uniform Medical Plan

Your health. Your plan. Your choice.

Network Hospital Billing & Administrative Manual

Washington State Health Care Authority

Public Employees Benefits Board

HCA 54-793 (8/04)

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Claims Processing and Preauthorization

Benefits information
Customer service
Claims information
Enrollee eligibility information
Medical review
Notification/preauthorization

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

Provider services:
Toll-free 1-800-464-0967
Local 425-686-1246
Fax 425-670-3199

Active enrollees:
Toll-free 1-800-762-6004

Retired enrollees:
Toll-free 1-800-352-3968

Automated Enrollee Eligibility Information

Toll-free 1-800-335-1062

Provider Credentialing

Change of provider status
New provider enrollment
Provider contract information

Health Care Authority
Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

Toll-free 1-800-292-8092
Local 206-521-2023
Fax 206-521-2001

General Program Information

Fee schedule information
Policies and procedures
Training support

Health Care Authority
Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

Toll-free 1-800-292-8092
Local 206-521-2023
Fax 206-521-2001

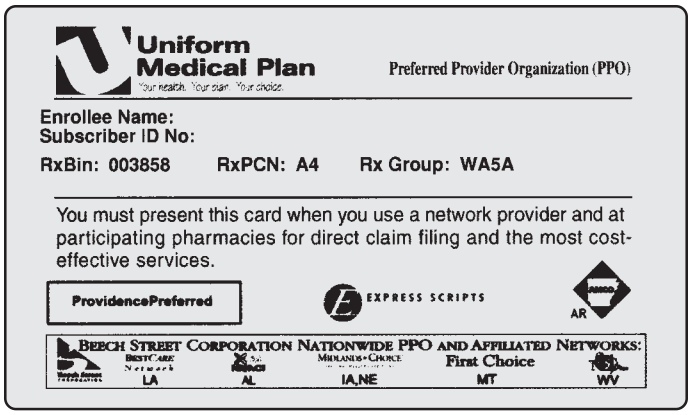
Web Site Information

Billing and administrative manuals, *Certificates of Coverage*, *Network Provider and Pharmacy Directory*, fee schedules, APDRG and APC weights: **www.ump.hca.wa.gov**.

1.2 Sample Uniform Medical Plan (UMP) Identification Card

This is the I.D. card that confirms UMP Preferred Provider Organization (UMP PPO) enrollment. Please note that effective January 1, 2003 the UMP no longer uses social security numbers to identify UMP subscribers or enrollees. Subscriber I.D. numbers remain a nine-digit number and are prefixed by a "W" on the I.D. card.

A sample of the UMP Neighborhood I.D. card is included in Appendix 5, Section 1.2.



The card does not guarantee coverage. To confirm eligibility or obtain benefit information and requirements for prior approval, contact the plan at 1-800-762-6004 or in Seattle at 425-670-3000.

To find a network provider:

- **In Washington and Idaho** counties of Bonner, Kootenai, Latah and Nez Perce – www.ump.hca.wa.gov or call UMP customer service: Toll Free: 1-800-762-6004 Seattle: 425-670-3000
- **In Oregon** – The Providence Preferred Providers (PPO) www.providence.org/health_plans or call UMP Customer Service.
- **Elsewhere in U.S.** – www.beechstreet.com or 1-800-937-2277.

Send medical claims to: (Electronic Payer ID: 75243)
Uniform Medical Plan PO Box 34850, Seattle WA 98124-1850

Prescription drugs can be purchased at participating retail pharmacies or through our delivery by mail service. For more information contact Express Scripts at 1-866-576-3862 or www.express-scripts.com.

1.3 Claims Submission Information

Paper claims (UB-92) should be mailed within 60 days of service to the UMP claims payer at the following address:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34850
Seattle, WA 98124-1850

Claims with missing, inaccurate, or invalid information will be denied or sent back for clarification and resubmission.

Electronic claims submission is a more efficient way of doing business. If you are not already submitting claims electronically to the UMP, you may wish to contact one of the following clearinghouses for more information on how to get connected to send claims electronically.

Electronic Claims Clearinghouse	Contact
Electronic Network Systems	1-800-341-6141 **www.enshealth.com**
WebMD /Envoy	1-800-215-4730 **www.WebMD.com**
ProxyMed	1-800-586-6870 **www.proxymed.com**

If you are connected to one of these clearinghouses but are not yet submitting UMP claims electronically, submit your UMP claims to payer I.D. number 75243.

1.4 Provider Enrollment Information

To promote quality of care, UMP benefits are structured to encourage enrollees to use the services of providers who participate in the UMP provider network. Enrollees typically pay coinsurance of 40 percent or more when they use non-network providers.

As a network UMP facility, you are required to refer patients to other network providers or facilities except where none is available or in case of an emergency. The UMP recognizes that most providers have established referral patterns. If the providers you routinely refer to are non-network, but are interested in joining the UMP provider network, please refer them to the Provider Services Division by calling 1-800-292-8092 or 206-521-2023. Please note, however, that all providers must meet UMP credentialing criteria prior to receiving network provider status.

1.5 Preauthorization/ Notification

To provide notification for select principal/primary diagnoses; to request preadmission certification for skilled nursing facility admissions; or to request preauthorization for organ transplants, hospice care, home health care, durable medical equipment, or other services as required by the *Certificate of Coverage*, call 1-800-464-0967.

Section 2:
Program Outline/Reimbursement

Questions regarding development of reimbursement rates and policies? Call 206-521-2023 or 1-800-292-8092.

2.1 Overview of the Uniform Medical Plan

The Uniform Medical Plan (UMP) is a self-insured, preferred provider medical plan for public employees and retirees. It is sponsored by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA).

The UMP provides coverage for many alternative/complementary, medical, surgical, and obstetric services; chemical dependency and mental health treatment; organ transplants; and prescription drugs. All enrollees have benefits for routine preventive care, vision and hearing examinations, and diabetic education.

See the UMP *Certificate of Coverage* for deductible, coinsurance, and copayment requirements, as well as for a complete description of benefits.

2.2 Inpatient Reimbursement for Acute Care Hospitals (Excluding Low-Volume and Pediatric Hospitals)

The primary basis for the UMP inpatient hospital payment is the All-Patient Diagnosis Related Group (APDRG) per-case system. With some specific exceptions, hospitals with at least 1,000 cases per year for all payers other than Medicare and Medicaid (as determined from the Department of Health's Comprehensive Hospital Abstract Reporting System, or CHARS) are reimbursed for inpatient care on a per-case basis. Exceptions include pediatric hospitals that, along with low-volume hospitals, are paid on a per diem basis; specialized providers, such as the Seattle Cancer Care Alliance; and certain categories of cases described on the following page. The reimbursement for APDRG claims is determined by multiplying the applicable APDRG relative weight by the hospital-specific conversion factor.

APDRG Relative Weight: Each APDRG is assigned a weight that measures the relative cost of treating patients in that APDRG compared to the cost of treating the average patient.

Conversion Factor: The conversion factor is a dollar amount, specific to each hospital. The conversion factor is developed from an initial base rate that represents statewide average operating costs per case. The initial base rate is adjusted on a hospital-specific basis that recognizes capital expenditures, area wage differences, direct and indirect teaching costs, increased resources required to treat low-income patients, margin, uncompensated care, and inflation.

Cases excluded from per-case payment:

- Cancer research centers;
- Organ transplants (except cornea) covered by the UMP, which are reimbursed at a hospital-specific percent of charge rate;
- Psychiatric, chemical dependency, and rehabilitation APDRGs, which are reimbursed on a hospital-specific per diem basis;
- Low-volume APDRGs;
- Patients discharged/transferred to another distinct-part unit of the same hospital;
- Patients who leave against medical advice; and
- Patients discharged alive on the same day of admission (except normal delivery and normal newborn patients), which are reimbursed at a hospital-specific percent of charge rate.

2.3 Inpatient Reimbursement for Low-Volume and Pediatric Hospitals

The UMP has defined a set of low-volume hospitals and pediatric hospitals for which per-case reimbursement is not applicable. These hospitals are reimbursed using either a medical or surgical per diem. The reimbursement is determined by multiplying the applicable per diem rate (medical or surgical) by the length of stay for the case. The applicable per diem rate is determined by classifying a case into an APDRG, each of which has been defined as either medical or surgical.

The per diem rates for the low-volume hospitals were developed in a manner similar to the conversion factors for per-case hospitals, starting with state-wide medical and surgical per diems, which were then adjusted for hospital-specific circumstances. The per diem rates for the two pediatric hospitals are based on historic, hospital-specific data. In addition, a hospital-specific percent of allowed charges rate is used for transplants occurring at the pediatric hospitals.

2.4 Outpatient Hospital Reimbursement

Services provided in a hospital outpatient setting are reimbursed using the Ambulatory Payment Classification (APC) methodology, at a percent of allowed charges or according to the UMP Professional and Clinical Lab Fee Schedule, depending on the type of service and provider type. Please refer to Payment Addendum A of your *Network Provider Agreement for Hospitals*.

APC Relative Weights: The UMP weights are the same as those used by CMS. For current CMS relative weights, please refer to either the UMP Web site at **www.ump.hca.wa.gov** or the CMS Web site at **www.cms.hhs.gov**.

Conversion Factor: The conversion factor is a dollar amount, specific to each hospital, that is developed similarly to that of the APDRG inpatient conversion factor.

Hospitals/facilities excluded from APC reimbursement:

- Ambulatory surgical centers
- Pediatric hospitals

- Critical access hospitals
- Military and veteran's hospitals
- Out-of-state hospitals
- Psychiatric hospitals
- Rehabilitation hospitals
- Rural hospitals, as defined by the Department of Health's Peer Group

2.5 Advantages of Network Participation

There is a strong financial incentive built into the UMP's benefit design to encourage enrollees to use network providers. Specifically, enrollees who use network hospitals pay a $200 per day copay up to a maximum of $600 **per year** for inpatient treatment. Subscribers who choose to receive services at an in-area non-network hospital are responsible for the difference between billed charges and 60 percent of the allowed amount.

Example: Mr. Jones is admitted to Hospital A, which is **not** a UMP network hospital. Allowed charges for a four-day stay equal $4,000. Assuming the annual deductible has been met, the UMP will pay $2,400 and the enrollee responsibility is $1,600.

If Mr. Jones had been admitted to a UMP network hospital, his responsibility would have been $600.

Section 3:
Billing Instructions for Inpatient and Outpatient Hospital Services

3.1 Claim Submission

Providers are required to use the UB-92 claim form or electronic equivalent. Claims with invalid ICD-9, CPT, and/or HCPCS Level II codes will be denied. Incomplete claims will cause either delay or denial of claims payment. Inpatient hospital claims will not be accepted on an interim basis. For inpatient hospital claims, only those for final discharge billing will be processed. Inpatient claims from skilled nursing facilities will be accepted for processing on a monthly basis.

3.1.1 Claim Submission Process

Claims submitted on paper must be mailed to the UMP:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34850
Seattle, WA 98124-1850

Hospital providers are required to use the CMS-1450 claim form. Incomplete claims will cause delay or denial of claims payment. Services submitted with invalid procedure, diagnoses, or place of service codes will be denied.

You are encouraged to submit claims electronically. See Section 1.3, Claims Submission Information, to find out more about this option.

3.1.2 Timely Submission of Claims

Claims for covered services provided to an enrollee should be submitted within 60 days of the date of service. The UMP will not process claims submitted more than 12 months after the date of service. Under exceptional circumstances, such as when the UMP is secondary and the primary payer has not paid on a timely basis, this provision may be waived upon approval by the UMP.

To request a waiver, send a written memorandum explaining the circumstances to:

Manager, Customer Service
Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34850
Seattle, WA 98124-1850

3.1.3 Process for Resubmission of Claims and Adjustments

To resubmit a claim that was previously denied for correction or clarification, simply resubmit the claim containing the requested information with your regular batch.

To request an adjustment to a previously paid claim, network providers should contact the UMP by phone at 1-800-464-0967, or write to:

Uniform Medical Plan (or UMP Neighborhood)
P.O. Box 34850
Seattle, WA 98124-1850

If the UMP agrees that the claim warrants adjustment, the provider may be required to submit the corrected claim with supporting documentation and attach a letter stating the reason that the claim should be adjusted. Adjustment claims are identified by a "6" entered in Form Locator 4 (Type of Bill), 3rd digit.

3.1.4 Interim Claims Policy: Inpatient Claims

For inpatient admissions, interim claims are not accepted from network hospitals. UB-92 claim forms with a "30" in Form Locator 22 (Patient Status) and/or a "2," "3," or "4" entered in Form Locator 4 (Type of Bill), 3rd digit, will be returned to the hospital. Only "admit through discharge" claims ("1" in Form Locator 4, 3rd digit) are accepted for payment.

Under exceptional circumstances of hardship, a hospital may appeal on a case-specific basis to the UMP for a waiver of this policy. To appeal for a waiver, contact:

Manager, Customer Service
Uniform Medical Plan (or UMP Neighborhood)
P.O. Box 34850
Seattle, WA 98124-1850

3.1.5 Enrollee Appeals Procedure for Denied Claims

If a UMP enrollee feels that a claim has been incorrectly processed or payment wrongly denied, it is the responsibility of the enrollee to contact the UMP. Retirees should call 1-800-352-3968; all other enrollees should call 1-800-762-6004. If the problem is not resolved to the satisfaction of the enrollee, he or she may appeal to:

Uniform Medical Plan (or UMP Neighborhood)
P.O. Box 34578
Seattle, WA 98124-1578

Details of this process can be found in the current *Certificates of Coverage.*

3.1.6 Audit and Right of Recovery Policy

The UMP's right to audit, inspect, and duplicate records maintained on enrollees by network providers is discussed in the contract between the HCA/UMP and the provider.

Similarly, the UMP's right to seek prompt refund from the provider for any duplicate, erroneous, or excess payments, or to deduct the amount overpaid from future payments, is also discussed in the contract between the HCA/UMP and the provider.

3.1.7 Patients' Rights to Confidentiality

It is the responsibility of the provider to keep audit, billing, payment, medical, and other patient-related information for UMP enrollees confidential, except as necessary for performance of the contract between the HCA/UMP and the provider, unless required by law to do otherwise. The Notice of Privacy Practices is located on the UMP Web site and a hard copy is available on request.

3.2 Itemized Billing Statement and Medical Records

3.2.1 Prospective Payment Claim Review

The UMP does not normally require itemized billing statements with the UB-92 claim form. However, for inpatient claims in excess of $50,000, outpatient claims in excess of $10,000, or claims that are suspended or audited prospectively (that is, before payment) for other reasons, itemized billing statements and copies of invoices substantiating usual and customary charges may be requested by the UMP.

Medical records are required for claims identified by the Medicare Code Editor as "questionable admissions," based on a principal diagnosis that is not usually sufficient justification for admission to an acute care hospital.

In addition, the UMP may request medical records for a case in which it is not clear that the treatment performed is covered or is medically necessary. In these situations, however, a special request will be made to the hospital. UMP will not pay copy or administrative charges for copies made for considering a claim before payment, or for reconsidering a claim at the request of the hospital or other provider.

3.2.2 Retrospective Payment Claim Review

On occasion, the UMP may initiate a post-payment hospital bill audit for select claims. If a claim is selected for post-payment review, the hospital will allow examination or audit and copying by or for the UMP of all data and other records maintained on or relating to the care, billing, and costs for UMP enrollees. This examination and copying shall be allowed upon reasonable notice during regular business hours. The examination and copying may be done for any services until 12 months after the UMP has paid for that service.

UMP will reimburse the hospital for copy charges for retrospective review (which means review done after the claim has been paid or partially paid) according to the applicable Payment Addendum, if the review is requested by UMP. UMP will not pay any administrative fees for copying and will not pay any fee for auditing charges or the like.

3.3 Balance Billing Policy

Network providers agree to accept the UMP hospital payment as full compensation for covered services, and agree not to bill enrollees for any amounts above the contracted payment amount.

The enrollee is responsible for any applicable deductible, coinsurance, copayment, and/or payment for non-covered services. The network provider is liable for services determined to be medically unnecessary upon retrospective review, unless a waiver signed by the patient is on file with the hospital substantiating that the patient knew the services would not be covered prior to the provision of these services.

When the UMP is secondary, and the primary payer has a contractual agreement with the hospital, the hospital may not balance bill the UMP for charges in excess of the primary payer's contracted amount.

The patient **cannot** be billed for:

- Any amounts above the maximum allowance;
- Any portion for which the UMP is responsible; or
- Any covered services for which medical necessity cannot be established by the UMP. An exception to this requirement is made if the patient understood, prior to receiving the service(s), that the service(s) would not be covered by the UMP, and agreed in writing to assume financial responsibility for the service(s).

The patient **can** be billed for:

- Any applicable deductible, copayment, or coinsurance;
- Any charges for UMP-excluded services; or
- Any charges for services that exceed the benefit limit.

3.4 Definition of Inpatient

An inpatient is defined as a Uniform Medical Plan (UMP) enrollee who has been admitted to the hospital, incurs room and board services, and is expected to remain 24 hours or longer.

For APDRG-based network providers, the APDRG payment amount includes all pre-admission, diagnostic, appliance, pharmaceutical, operative, treatment, and room and board charges for the patient, for the period beginning one calendar day prior to the date of admission and extending through date of discharge.

If the hospital has an ambulatory surgery program or a "day patient" program where an enrollee receives services which require a hospital stay of less than 24 hours, services must be billed as outpatient.

The UMP will work with the hospital should any question arise as to appropriate site of care or to address any unique service arrangements provided by the hospital.

3.5 Billing Form and Coding Standards

UMP hospital inpatient and outpatient claims must be submitted using a Uniform Billing Form (UB-92) or the electronic equivalent. Incomplete claims will cause either a delay or denial of claims payment. The UMP recognizes data elements as defined by the National Uniform Billing Committee (NUBC). Standard UB-92 revenue codes are required on all service lines of a claim.

The most current versions of the ICD-9-CM diagnosis and procedure codes or CPT/HCPCS codes are required for billing purposes. As the diagnosis and procedure codes are revised quarterly/annually by CMS and the AMA, the updated codes should be used for UMP claims, beginning at the same time that the codes become valid for use with Medicare claims.

All diagnosis and procedure codes on the claim form will be edited for validity and accuracy using the Inpatient Medicare Code Editor or Outpatient Code Editor, as applicable. Claims with invalid, out-of-date, non-specific, or inaccurate codes will be sent back to the hospital for clarification, resulting in delayed reimbursement.

For cases that are not reimbursed on an APDRG per-case or per diem basis, a semi-private room rate is used to determine allowed charges. The UMP may pay for private rooms (revenue codes 111-119 and 141-149) when determined to be medically necessary.

3.5.1 Outpatient Revenue Code Billing Instructions

The following revenue codes are accepted by the UMP when billed without a corresponding CPT/HCPCS code. When billed by a facility reimbursed under Outpatient Prospective Payment System (OPPS), these services (with the exception of 253 - Take Home Drugs) are packaged services for which no separate payment is made. However, the cost of these services is included in the outlier calculations.

Revenue Code	Description
250	Pharmacy - General Classification
251	Pharmacy - Generic Drugs
252	Pharmacy - Non-Generic Drugs
253	Pharmacy - Take Home Drugs
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
257	Non-Prescription Drugs
258	IV Solutions
259	Other Pharmacy
260	IV Therapy - General Classification
262	IV Therapy/Pharmacy Services
263	IV Therapy/Drugs/Supply Delivery
264	IV Therapy/Supplies

Revenue Code	Description
269	Other IV Therapy
270	Medical - Surgical Supplies
271	Non-Sterile Supply
272	Sterile Supply
273	Take Home Supplies
274	Prosthetic/Orthotic Devices
275	Pacemaker
276	Intraocular Lens
277	Oxygen - Take Home
278	Other Implants
279	Other Supplies/Devices
280	Oncology - General Classification
289	Other Oncology
290	Durable Medical Equipment
370	Anesthesia - General Classification
371	Anesthesia - Incident to Radiology
372	Anesthesia - Incident to Other Diagnostic Services
374	Acupuncture
379	Other Anesthesia
390	Blood - General Classification
399	Other Blood Storage and Processing
560	Medical Social Services - General Classification
569	Medical Social Services - Other Medical Social Services
621	Supplies Incident to Radiology
622	Supplies Incident to Other Diagnostic Services
630	Drugs Requiring Specific Identification, General Class
631	Single Source
632	Multiple
633	Restrictive Prescription
637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic Coma)
700	Cast Room - General Classification
709	Other Cast Room
710	Recovery Room - General Classification
719	Other Recovery Room
720	Labor Room/Delivery - General Classification

Revenue Code	Description
721	Labor
760/761	Treatment/Observation Room (non-APC facilities only)
762	Observation Room
810	Acquisition of Body Components
819	Other Donor

All other revenue codes that are billable on a hospital outpatient claim must contain a CPT/HCPCS code. Claims with missing or invalid CPT/HCPCS codes will be rejected by the UMP.

3.5.2 Type of Bill

Type of Bill (Form Locator 4) is used to indicate the type of facility and bill classification (inpatient, outpatient, etc.) specific to a claim. Type of Bill is used by the UMP in the claims adjudication process and is a required field.

The bill types that are reimbursed under UMP's Ambulatory Payment Classification (APC) reimbursement methodology are:

13X Hospital Outpatient (including ASC)

14X Hospital Outpatient—other

3.5.3 Line Item Dates of Service

The UMP requires line item dates of service to be reported on all outpatient bills for each line where a HCPCS code is required, including claims where the "from" and "through" dates are the same. Omission of these dates will delay processing.

3.5.4 Service Units

The UMP recognizes a service unit as the number of times a service or procedure being reported was performed.

3.5.5 Modifiers - CPT (Level I)

The UMP will accept the following:

-25 Modifier for Evaluation & Management services

-50 Bilateral

-52 Reduced services

-58 Modifier for staged or related procedures

-59 Modifier for distinct services

-73 Discontinued outpatient hospital surgical procedure (ASC) or diagnostic procedure/service prior to the administration of anesthesia

3.5.5 Modifiers - CPT (Level I) - (continued)

-74	Discontinued outpatient hospital surgical procedure (ASC) or diagnostic procedure/service after the administration of anesthesia
-76	Repeat procedure by same physician
-77	Repeat procedure by another physician
-78	Return trip to the Operating Room
-79	Unrelated procedure during post-operative period

3.5.6 Modifiers - HCPCS (Level II)

LT	Left Side
RT	Right Side
E1	Upper Left Eyelid
E2	Lower Left Eyelid
E3	Upper Right Eyelid
E4	Lower Right Eyelid
FA	Left Hand, Thumb
F1	Left Hand, Second Digit
F2	Left Hand, Third Digit
F3	Left Hand, Fourth Digit
F4	Left Hand, Fifth Digit
F5	Right Hand, Thumb
F6	Right Hand, Second Digit
F7	Right Hand, Third Digit
F8	Right Hand, Fourth Digit
F9	Right Hand, Fifth Digit
LC	Left Circumflex Coronary Artery
LD	Left Anterior Descending Coronary Artery
RC	Right Coronary Artery
QM	Ambulance Service (arranged by provider)
QN	Ambulance Service (furnished by provider)
TA	Left Foot, Great Toe
T1	Left Foot, Second Toe
T2	Left Foot, Third Toe
T3	Left Foot, Fourth Toe
T4	Left Foot, Fifth Toe
T5	Right Foot, Great Toe
T6	Right Foot, Second Toe
T7	Right Foot, Third Toe
T8	Right Foot, Fourth Toe
T9	Right Foot, Fifth Toe

3.5.7 Repetitive Services

Please follow Medicare billing guidelines.

3.5.8 Late Charges

Late charges must be submitted as an adjustment to the original claim.

3.5.9 Outpatient Code Editor (OCE) Edits

The UMP will follow CMS guidelines and applicable versions of the OCE, which are generally updated in January, April, July, and October. The UMP recognizes that some Medicare inpatient-only procedures may be appropriate in an outpatient setting and will reimburse those procedures under the percent of billed charge portion of your hospital agreement.

3.6 APDRG and APC Grouping of Claims

At the time an inpatient claim is submitted, the Uniform Medical Plan (UMP) will assign the claim to an All-Patient Diagnosis Related Group (APDRG). The grouping and pricing methodology used is based on patient discharge date. Outpatient hospital claims reimbursed under the Outpatient Prospective Payment System (OPPS) will be grouped to the appropriate APC based on service date. Hospitals are not required to group claims prior to submission.

3.7 Outpatient Observation–APC Billing

Hospitals billing for observation should follow CMS billing policy. The UMP follows CMS coverage criteria when determining whether observation services are eligible for separate APC reimbursement. Observation services eligible for separate reimbursement are calculated using a single unit.

Section 4:
Provider Information

4.1 Provider Requirements

Uniform Medical Plan (UMP) network hospitals and hospital-based physicians agree to comply with the requirements outlined in this section.

4.1.1 Credentialing

- Maintain licensure, registration, and/or certification in the state of Washington.
- Maintain professional liability insurance coverage with limits of liability as determined by the UMP.
- Meet all other credentialing requirements documented in your Network Provider agreement as determined by the UMP.
- Accept UMP fee schedules and follow UMP policies and procedures.

4.1.2 Billing

Call 425-670-3046 or 1-800-464-0967.

- Bill the UMP your usual and customary fee.
- Submit claims on UB-92 form for hospital or skilled nursing facility inpatient or outpatient claims, or CMS-1500 forms for professional fees, within 60 days after the covered services are rendered. Claims cannot be submitted later than 365 days from the date of the covered service(s), except as noted in Section 3.1.2.
- Ensure that enrollees are not billed for any amounts above the maximum allowance.
- Collect applicable deductibles, copayments, and coinsurance from UMP enrollees after receiving the detail of remittance documenting the amount the enrollee can be billed.

4.1.3 Referrals and Authorizations

- Refer enrollees to UMP network providers and network facilities, except where no appropriate network provider is available or in case of an emergency.
- *The Network Provider Directory* located in Appendix 2 of this manual contains a listing of UMP network providers by city and specialty. Network home health and hospice agencies, including infusion therapy providers, are listed by counties served. This directory is updated annually. Non-network providers can apply for network status by contacting the UMP. All providers must meet the UMP selection criteria prior to receiving network provider status. Because the UMP's provider network continues to expand, it is important to verify a provider's network status prior to making a referral.

- Call the UMP to obtain preauthorization for diagnoses listed in Section 6.1.5 of this manual.
- Notify the UMP of hospital stays exceeding 10 days and admissions for certain diagnoses, as requested by the UMP. See Section 6 of this manual for detailed information about the UMP utilization review requirements. In addition, see the applicable UMP *Certificate of Coverage*, which outlines other notification/preauthorization requirements, as well as defines those services which are covered, those which have limitations, and those which are excluded.

Section 5:
Enrollee Overview

Patient questions regarding benefits, network provider status, claims payment? For information on active employees, call 1-800-762-6004. For information about retirees, call 1-800-352-3968.

5.1 Enrollee Requirements

Enrollee education is an important factor in ensuring the timely and appropriate payment of health care benefits. UMP subscribers are instructed to follow these guidelines when obtaining health care services:

- Choose a provider from the *Network Provider Directory,* as found in Appendix 2 of this manual, or call the UMP customer service number.
- Verify that the services they are obtaining are covered by the UMP by referring to their UMP *Certificate of Coverage*, as found in Appendix 1 of this manual, or by calling the UMP.
- Identify themselves as a UMP enrollee when calling for an appointment.
- Present their identification card at the time services are rendered.
- Remind their physician to refer them to UMP network providers and to admit them to UMP network hospitals.
- Obtain preauthorization from the UMP for:
  - Biofeedback;
  - Cardiac and pulmonary rehabilitation;
  - Cochlear implants;
  - Durable medical equipment for rentals beyond three months or purchases over $1,000;
  - Genetic testing (genetic testing unrelated to pregnancy may be authorized only when performed by a specialist center/provider designated by the UMP);
  - Growth hormones;
  - Home health care in which visits are daily, expected to exceed two hours a day, or length of treatment is expected to last more than 14 consecutive days. Reauthorization is required every two weeks unless determined otherwise by Medical Review. (Please call 1-888-759-4855 prior to the start of home health services in these cases.)
  - Hospice care (in order to be covered at the highest level of benefit);
  - Inpatient admissions for rehabilitation (physical, occupational, speech, and massage therapy);
  - Obstetric services in a birthing center;
  - Obstetric services provided by limited-license providers;
  - Organ transplants, including stem cell and bone marrow;
  - Positron emission tomography (PET) scans;
  - Respite care;

- Skilled nursing facility admissions;
- Some prescription drugs (see the UMP Web site at **www.ump.hca.wa.gov** for an up-to-date list of drugs that require preauthorization); and
- Temporomandibular joint (TMJ) surgery.

In addition, some frequently prescribed durable medical equipment, such as light boxes, hospital beds, and breast pumps, are covered only when they have been determined to be medically necessary. It may be to your patient's benefit to request preauthorization on these items.

- Promptly remit applicable deductibles, coinsurance, copayments, and/or payment for non-covered services. (**Please note:** For outpatient services, if the APC allowed charge is greater than the billed charge, the member's coinsurance will be based on the billed charge. The UMP will reimburse the difference to the provider.)

If patients have questions regarding benefits, network provider status, or payment of claims, please refer them to the UMP at the numbers referenced at the beginning of this section.

Section 6:
Utilization Review

Notification/preauthorization questions?
Call 425-670-3046 or 1-800-464-0967.

6.1 Utilization Review Requirements

6.1.1 Overview

The UMP Medical Review professionals perform utilization and quality review, as well as case management services for our enrollees.

For preauthorization and prenotification services or information related to eligibility, call the numbers at the beginning of this section.

The UMP's utilization management program includes review of certain medical services before, during, and after they are delivered. Reviews are conducted for:

- Optional case management (selected complex or high-expense cases);
- Prenotification for certain diagnoses;
- Required case management; and
- Retrospective (postpayment) review.

The purpose of the review is to determine whether services are medically necessary and delivered in the most appropriate setting. Such reviews help to:

- Monitor quality of care;
- Ensure that treatment is necessary and consistent with good medical practices;
- Discourage unnecessary care;
- Save health care dollars; and
- Identify chronic and catastrophic cases appropriate for case management.

6.1.2 Notification of Hospital Admissions

The purpose of this program is to allow for the earliest possible identification of UMP patients for whom case management services may be appropriate. Any hospital stay exceeding 10 days must be reported to the UMP.

Also, please call the UMP to report complex patient cases that may be assisted by our nurse case managers. The UMP is currently in the process of re-evaluating its diagnosis admission list. When the revised list is available, the attending physician or hospital representative should call the UMP to report any UMP enrollees who are admitted to the hospital for one of these diagnoses. The medical condition of the enrollee will be evaluated to determine if case management is indicated.

Notification is not required when Medicare or another benefit plan that requires notification or preauthorization is the primary payer.

Note: The notification process does not involve approval for medical necessity or preauthorization of services. However, these admissions may be subject to retrospective (postpayment) review.

6.1.3 Case Management

Optional Case Management

Case management is a collaborative process that may include a nurse case manager coordinating with physicians, hospitals, skilled nursing facilities, or other facilities by telephone or on-site visits. This will require the cooperation of the facility and the attending physician, with the consent of the enrollee.

Generally, cases are identified as candidates for case management through the notification process. However, a facility or provider may identify a patient with a chronic or catastrophic illness as a potential candidate for case management. In this instance, the facility or provider should call the UMP at 1-888-759-4855.

Required Case Management

The UMP Medical Director or his or her delegate may review an enrollee's medical records and determine whether the enrollee's use of medical services is unsafe, potentially harmful, excessive, or medically inappropriate. Based on this review, the UMP may require an enrollee to participate in and comply with a case management plan as a condition of continued payment for services under the UMP.

Case management may include, but not be limited to, designating a primary provider to coordinate care and/or designating a single hospital and pharmacy to provide covered services or medications. The UMP has the right to deny payment for any services received outside the required case management plan with the exception of medically necessary emergency services provided outside the service area.

6.1.4 Review Criteria and Quality Screens

The UMP professional staff use multiple resources, including Medicare coverage criteria, payment policies, and manuals; and other national guidelines when conducting case reviews. In the majority of cases, UMP follows Medicare coverage and billing guidelines. If the nurse determines that a case does not meet the review criteria, the case will be referred to the UMP Medical Director. The decision to approve or deny is made by the UMP Medical Director after consultation with the attending physician, when appropriate, and is based on medical experience and expertise.

6.1.5 Preauthorization

To ensure that standard benefits are received by the enrollee, prior authorization by the plan must be received before you render the following services:

- Biofeedback.
- Cardiac and pulmonary rehabilitation.
- Cochlear implants.

- Durable medical equipment for rentals beyond three months or purchases over $1,000.
- Genetic testing (genetic testing unrelated to pregnancy may be authorized only when performed by a specialist center/provider designated by the UMP).
- Growth hormones.
- Home health care in which visits are daily, expected to exceed two hours a day, or length of treatment is expected to last more than 14 consecutive days. Reauthorization is required every two weeks unless determined otherwise by Medical Review. (Please call 1-888-759-4855 prior to the start of home health services in these cases.)
- Hospice care (in order to be covered at the highest level of benefit).
- Inpatient admissions for rehabilitation (physical, occupational, speech, and massage therapy).
- Obstetric services in a birthing center.
- Obstetric services provided by limited-license providers.
- Organ transplants, including stem cell and bone marrow.
- Positron emission tomography (PET) scans.
- Respite care.
- Skilled nursing facility admissions.
- Some prescription drugs (see the UMP Web site at **www.ump.hca.wa.gov** for an up-to-date list of drugs that require preauthorization).
- Temporomandibular joint (TMJ) surgery.

In addition, some frequently prescribed durable medical equipment such as light boxes, hospital beds, and breast pumps, are covered only when they have been determined to be medically necessary. It may be to your patient's benefit to request preauthorization on these items.

See the UMP *Certificate of Coverage* for specific information on preauthorization requirements and scope of coverage of these benefits.

6.1.6 Requirements for Skilled Nursing Facilities (SNF): Medicare-Certified Only

Preauthorization is required for skilled nursing facility benefits, and treatment must meet medical necessity criteria. The enrollee must require continued services of skilled medical or allied health professionals that cannot be provided on an outpatient basis. To request preauthorization, call the UMP at the numbers referenced at the beginning of this section.

Medical review is not required when Medicare or another benefit plan that requires preauthorization is the primary payer and is providing benefits. If Medicare or another benefit plan is denying coverage, preauthorization, including medical review for medical necessity, will be required by the UMP.

At the time of preauthorization, all cases will be screened for case management referral.

Section 7:
Payment Policy

7.1 Payment Arrangements

Payment rates are stipulated in the contract between the hospital and the UMP. Inpatient claims are paid using the rates in effect on the date of discharge. Outpatient claims are paid using the date of service.

All features of the UMP's benefit design are applied based on the admission date of the patient. This includes, for example, determination of covered services, deductibles, copayments, and provider status (e.g., network or non-network). If the provider loses network provider status, payment is based on the contractual arrangement in effect when the enrollee was admitted to the hospital.

7.1.1 UMP *Certificate of Coverage*

The applicble UMP certificate of coverage (COC) (available on the UMP Web site at **www.ump.hca.wa.gov** or by calling 1-800-762-6004) is the official source of plan benefits and scope of coverage information. Throughout this section of the billing manual, key information from the applicable COC that is pertinent to the benefit under discussion may be referenced for the provider's information. **Providers must rely on the COC to obtain full and complete information regarding the scope of coverage and benefit provisions.** Refer to the How the UMP Works section of the COC for a listing of provider types approved to deliver services.

7.1.2 Plan Payment Provisions for Providers

Unless otherwise specified in the COC, the enrollee's applicable calendar year deductible must be satisfied before the plan will make a payment for services provided under a given benefit.

Services exempt from the annual medical/surgical deductible include:

- Preventive care*;
- Retail and mail-order prescription drugs**;
- Routine vision exams and hardware;
- Required second surgical opinions; and
- Tobacco cessation services provided through the *Free & Clear* smoking cessation program.

*The UMP follows the preventive care guidelines established by the U.S. Preventive Services Task Force (USPSTF) when determining coverage for preventive care. See Section 7.2.2, Preventive Care, of the *Billing & Administrative Manual for Professional Providers* for more information.

**The UMP has a separate annual deductible for prescription drugs. It is a combined retail and mail-order deductible. See the applicable UMP *Certificate of Coverage* for more details.

In the UMP PPO *Certificate of Coverage* and elsewhere, "non-network" and "out-of-network" refer to services from providers who are not contracted with UMP PPO. "Non-network" is usually used to refer to situations where the enrollee had the opportunity to use a UMP PPO provider but chose not to. "Out-of-network" refers to situations where the enrollee did not have access to a network provider, as determined by UMP. After the enrollee's annual medical/surgical deductible has been met, the plan's payment provisions generally are as follows:

- For **network providers (in Washington, Oregon, and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce)**, the plan pays 90 percent of the allowable amount. (The "allowable amount" is the actual charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent. (**Note:** A payment differential applies to certain categories of providers. This differential is described in the following section.)
- For **non-network providers and out-of-network providers**, the plan pays a lower percentage of the allowable amount. (The "allowable amount" is the actual charge or the fee schedule amount in Washington, whichever is less. In all other states, the allowable is based on a regionally adjusted charge.) When using a non-network or out-of-network provider, the enrollee is responsible for a higher coinsurance amount as well as any outstanding balance above the plan's allowable amount. Refer to the applicable UMP *Certificate of Coverage* for specific details regarding the payment provisions, plan benefits, and scope of coverage.

For network and out-of-network providers, these payment provisions are in effect until the out-of-pocket limit or benefit limit is reached. However, even if the enrollee's out-of-pocket limit is reached, out-of-network providers can still balance bill enrollees for the difference between the billed and allowed charges. For services from non-network providers, the annual out-of-pocket limit does not apply and the payment provisions above are in effect until the enrollee's lifetime maximum benefit limit is reached. Inpatient services are subject to the inpatient hospital copayments or coinsurance. For additional details regarding payment provisions, plan benefits and scope of coverage, see the applicable UMP *Certificate of Coverage*.

Note: *Through the Beech Street network (see directory at* **www.beechstreet.com***), UMP enrollees also have access to network providers outside of Washington, Oregon, and the four Idaho counties. However, covered services from Beech Street network providers in these other states are generally reimbursed at 80% of allowed charges.*

Also note: Services rendered under private contracts by providers who "opt out" of the Medicare program will not be covered or reimbursed by the UMP. Exceptions are services provided on an emergency/urgent basis or that are excluded under the Medicare program, such as routine eye exams and preventive care services/procedures, which will be processed and paid according to UMP benefits. In a private contract situation, the UMP enrollee is solely responsible for the provider's total billed charges.

7.1.3 Non-Covered Revenue Codes

Charges for the following services should be listed as noncovered (Form Locator 48); they will not be considered for payment.

Revenue Code	Description
180–189	Leave of Absence
220	Special Charges
256	Drugs/Experimental
257	Pharmacy - Non-Prescription
399	Other Blood Storage and Processing
670	Outpatient Other Special Residence
723	Newborn Circumcision
819	Other Donor
941	Recreational Therapy
942	Education/Training (with the exception of Diabetes Education)
948 & 949	Other Rx Svcs/Weight Loss
960–989	Professional Fees
990–999	Patient Convenience Items

Revenue code 220, Special Charges, requires submittal of additional information identifying and justifying the charges. For revenue code 942, Education/Training, the UMP provides benefits for Medicare-approved diabetes education programs and follows Medicare protocol and criteria. Revenue Codes 960 through 989, Professional Fees, are not covered when billed on a UB-92 form. These services must be billed separately with an appropriate Current Procedural Terminology (CPT) code on a CMS-1500 form or electronic equivalent. Where appropriate, the CPT "26" modifier indicating that the charges represent the professional component of the service must be billed on the CMS-1500 form. These fees are not bundled into All Patient Diagnosis Related Groups (APDRG) or a per diem reimbursement, but will be paid separately if submitted on a CMS-1500 form. If your hospital bills for these professional services using the hospital's own federal tax identifier, the claim will be paid as if the physician were a network provider, using the resource-based relative value scale (RBRVS) fee schedule as determined by the UMP. The patient may not be billed for professional charges that exceed the UMP allowable charge.

7.1.4 Services Prior to Admission

For cases paid on an APDRG per-case basis, all services provided within one calendar day prior to admission will be considered part of the admission and covered by the APDRG reimbursement rate. This includes, but is not limited to, radiology, pathology, and emergency room services. Any charges for services on the calendar day prior to admission must be

submitted on the inpatient UB-92 bill and not billed separately as an outpatient service. The Statement Covers Period, Form Locator 06, should reflect the admission date (From) and discharge date (Through).

7.1.5 Multiple Procedure Discounting

For multiple surgical procedures furnished under the same operative session, discounting will be as follows: 100% for the procedure with the highest weight, 50% for any additional surgical procedures. Surgical procedures terminated prior to the induction of anesthesia will be paid at 50% of the APC payment.

7.1.6 APC Outlier

For calendar years 2003 and 2004: A service will generate an additional outlier payment when the cost of the services (determined by converting charges to cost using the Medicare hospital ratio of Cost to Charge) exceeds a threshold of three times the APC payment amount. The additional outlier payment will equal 50 percent of any excess costs above the threshold.

7.2 Claim Payment Policy

7.2.1 Enrollee Appeals Procedure for Denied Claims

If a UMP enrollee feels that a claim has been incorrectly processed or payment wrongly denied, it is the responsibility of the enrollee to contact the UMP. Enrollees may contact UMP toll-free at 1-800-762-6004, or locally in the Seattle area at 425-670-3000. If the problem is not resolved to the satisfaction of the enrollee, he or she may appeal the decision by filing a written notice of appeal with the UMP. Details of this process can be found in the applicable UMP *Certificate of Coverage*.

7.2.2 Audit and Right of Recovery Policy

The UMP's right to audit, inspect, and duplicate records maintained on enrollees by network providers is discussed in the audit section of the contract between the UMP and the provider.

Similarly, the UMP's right to seek prompt refund from the provider for any duplicate, erroneous, or excess payments, or to deduct the amount overpaid from future payments, is discussed in the refunds section of the contract between the UMP and the provider.

7.2.3 Patients' Rights to Confidentiality

It is the responsibility of the provider to keep audit, billing, payment, medical, and other patient-related information for UMP enrollees confidential, except as necessary for performance of the contract between the UMP and the provider, unless required by law to do otherwise.

7.2.4 Coordination of Benefits (COB) Requirements

To receive payment when the UMP is in a secondary payer position, submit a copy of the original UB-92 claim form, along with a copy of the Explanation of Benefits (EOB) or Detail of Remittance (DOR) provided by the primary payer.

Effective January 1, 2003, the UMP adopted standard coordination of benefits. The UMP reviews the primary plan benefit calculation, and the primary plan payment, then UMP determines what the normal benefit would have been if UMP had been the only payer. The UMP compares the charges and determines which plan has the highest allowed charge. The UMP pays the difference between the highest allowed charge and the primary plan's payment, up to the normal UMP benefit amount.

7.2.5 Explanation of Benefits (EOB)

When the claim is paid, the patient receives an Explanation of Benefits (EOB) which shows the original submitted charges, any noncovered charges, the patient's responsibility, and the amount paid by the UMP.

The patient's EOB will also indicate when portions of the submitted charge have not been covered because the amount charged exceeds the contracted allowance for the service. The patient is not responsible for these charges and **cannot be** balance billed for them.

Patients may be confused when receiving EOBs for cases which have been paid either by APDRG or per diem arrangements, since the payments will bear no direct relationship to the billed charges. In order to reduce their confusion and minimize the number of follow-up phone calls from patients questioning their bills, a standard message will be printed on all EOBs for claims paid under an APDRG or per diem arrangement stating, "Per hospital contract with the Uniform Medical Plan, billed charges do not apply." (**Please note:** For outpatient services, if the APC allowed charge is greater than the billed charge, the member's coinsurance will be based on the billed charge. The UMP will reimburse the difference to the provider.)

7.2.6 Detail of Remittance (DOR)

Providers will receive a Detail of Remittance (DOR) from the UMP, which will indicate the amount of charges being reimbursed for each claim. A sample DOR can be found in Appendix 3. The DOR identifies the patient by name and identifier and captures the claim number assigned by the UMP. Then, for each service line of the claim, the DOR lists the service date, the procedure code of the service, submitted charges, noncovered charges and message code, network provider discounted amount, patient's responsibility, the amount paid, and the remaining balance for which the patient may be billed. It is recommended that providers not bill the patient for the applicable deductible or coinsurance until after a DOR has been received substantiating reimbursement by the plan.

7.3 Cost Outlier Payment Policy: Inpatient Claims

Outlier claims are those claims with unusually high or low costs. Catastrophic losses for which a hospital may be at risk are the major focus of the UMP's outlier policy.

High-Cost Outliers: High-cost outlier status is attained when the cost (defined as allowed charges multiplied by the inpatient percent of charges rate specified in the hospital's contract) exceed the specific outlier threshold for the APDRG. The outlier threshold is the greater of: (a) two times the APDRG payment (APDRG weight multiplied by the hospital's conversion factor) or (b) $16,000.

When high-cost outlier status is reached, the UMP will reimburse 100% of the costs that exceed the outlier threshold.

Low-Cost Outliers: Low-cost outlier claims are those claims for which allowable charges are less than: (a) two standard deviations below the mean charge (of the log distribution) for the APDRG, or (b) 5 percent of the inlier, whichever is greater. Low-cost outlier claims are reimbursed the APDRG payment amount or the contracted percent of allowed charges, whichever is less.

7.4 Late Claims and Relationship to High-Cost Outlier Payment Policy: Inpatient Claims

Late claims are defined as those claims that contain charges submitted by the hospital to the UMP after submission of the final claim. These claims are identified by a "5" entered in Form Locator 4 (Type of Bill), 3rd digit, of the UB-92 form.

For claims paid on an APDRG or per diem basis, all charges on late claims will be denied and the hospital notified with a message indicating that the case has been paid in full under the APDRG or per diem payment system.

In the case of claims paid on an APDRG per-case basis, it is possible that the allowable charges on a late claim could be sufficiently great to qualify the case for high-cost outlier reimbursement. If a hospital believes that this situation has occurred, **it is the hospital's responsibility to notify the UMP,** and request a review of the claim for possible readjudication. Such review will not occur automatically when late claims are received.

Submit written appeals for high-cost outliers to:

Manager, Customer Service
Uniform Medical Plan (or UMP Neighborhood)
P.O. Box 34578
Seattle, WA 98124-1578

7.5 Transfer Payment Policy: Inpatient Claims

APDRG-Based Network Providers: An APDRG-based network hospital that transfers an enrollee to another hospital is reimbursed the APDRG payment amount or the hospital's contracted percent of allowed charges, whichever is less. These cases are commonly referred to as transfer-out cases, and are defined on the UB-92 by a code of "02" entered in Form Locator 22, Patient Status.

Exceptions to the above payment policy are for APDRG 456 (Burn Transfer), and APDRGs 639 and 640 (Neonate Transfers). These APDRGs are

reimbursed the APDRG payment amount or as low-volume APDRGs, whichever is appropriate. Low-volume APDRGs are defined in the contract between the hospital and the UMP and are reimbursed the contracted percent of allowed charges. All transfer-out cases should be coded "02" in Form Locator 22.

Discharges/transfers to subacute care within the network hospital are reimbursed the lesser of the APDRG payment amount or the hospital's contracted percent of allowed charges. The acute care portion of the stay will be reimbursed according to the reimbursement methodologies outlined in Section 2 of this manual.

There is no special reimbursement arrangement for the receiving (also known as the transfer-in) hospital.

Per Diem-Based Network Providers: Transfer cases (into or out of the hospital) are reimbursed at the applicable medical or surgical per diem rate.

7.6 Readmission Payment Policy: Inpatient Claims

Inpatient cases in which a readmission for the same or a similar condition occurs within 30 days of a previous discharge may be reviewed by the UMP on a retrospective basis.

Provisions for retrospective review, refunds, and the dispute resolution process are covered in the Medically Necessary Services, and Refunds and Dispute Resolution sections, respectively, of the contract between the UMP and the hospital.

7.7 Identification of Transplant Cases: Inpatient Claims

Subject to preauthorization, those cases that group transplant APDRGs and all other organ transplants (except cornea) covered by the UMP are paid at the contracted percent of allowed charges rate.

All other organ transplants will be identified at the time that prenotification/ preauthorization certification occurs and will be adjudicated manually according to the contracted percent of allowed charges rate.

Section 8:
Provider Inquiries, Complaints, Reconsideration Procedures, and Dispute Resolutions

Please note: *The section below applies specifically to provider concerns. There is a separate appeals process for enrollees seeking a change in UMP coverage or benefit determinations. Complaints and appeals on behalf of enrollees should be addressed under that process, which is described in detail in the UMP* Certificate of Coverage.

Questions? Call 425-670-3046 or 1-800-464-0967.

8.1 Provider Inquiry, Complaint, Reconsideration Procedures, and Dispute Resolutions

The UMP has specific procedures for provider inquiries, complaints, and claim reconsideration requests. Definitions for each of these and the procedures follow.

8.1.1 Inquiry

A request for information or for an explanation.

If you have an inquiry such as a question on claims payment status, plan benefits, or enrollee eligibility, please call UMP Provider Services at 425-670-3046 or 1-800-464-0967. In most cases, your question will be answered right away.

8.1.2 Complaint

An expression of dissatisfaction submitted on behalf of a provider regarding:

- Coverage or payment for health care services; or
- UMP policies or practices.

To register a complaint, you may also contact UMP Provider Services at the above numbers, fax the complaint to 425-670-3197, or write to:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34578
Seattle, WA 98124-1578

Most complaints will be resolved immediately or within 24 hours of receipt. However, for more complex issues, the turnaround time for reviewing and responding to provider complaints may be up to 30 calendar days.

8.1.3 Reconsideration

A provider reconsideration is the re-evaluation of a previous decision by UMP in response to a provider's written request. The request may be in reference to:

- An adverse decision regarding a complaint;
- An unresolved claims processing issue; or
- A decision to deny, modify, reduce, or terminate payment, coverage, or preauthorization for health care services or benefits. (Note that issues raised specifically on behalf of an enrollee or at the direction of an enrollee follow a separate appeals process described in the UMP *Certificate of Coverage*, and are not considered provider reconsiderations.)

There are two levels of **Provider Reconsiderations:**

Level 1: Within 180 days of receiving the notice of action leading to the request, submit your request for reconsideration to:

Uniform Medical Plan
(or UMP Neighborhood)
First-Level Provider Reconsideration
P.O. Box 34578
Seattle, WA 98124-1578

Please include the date of service and indicate clearly the issues that you wish to be reconsidered. Your request will be assigned to the appropriate experienced UMP staff, depending upon the issue.

Most requests are completed within 30 calendar days of the date the UMP received your request for reconsideration. If the decision is to reprocess the claim, you will receive a Detail of Remittance as notification. Otherwise, you will receive a written response.

Level 2: If you do not agree with the decision at Level 1 of the reconsideration process, you may submit a request for further reconsideration to:

Uniform Medical Plan
(or UMP Neighborhood)
Provider Relations Committee
Second-Level Provider Reconsideration
P.O. Box 34578
Seattle, WA 98124-1578

Requests for Level 2 reviews must be submitted within 60 calendar days of the date of the Level 1 determination. Include all of the information that was reviewed through the Level 1 reconsideration process, a copy of the Level 1 determination and any other information or documentation you think may be helpful. Your request for Level 2 reconsideration will be reviewed by our Provider Relations Committee. Most decisions will be made within 30 calendar days from receipt of your request for reconsideration.

Please note: There are no further reconsideration processes available through the UMP for non-network providers. The Level 2 reconsideration

process is the final decision of the UMP. If you are a network provider and are not satisfied with the outcome of the second level determination, you may request a dispute hearing with the Administrator of the Health Care Authority (HCA), using the dispute resolution procedure described below.

8.1.4 Dispute Resolution

A network provider may request a dispute hearing with the Administrator of the HCA. This procedure is not offered to non-network providers. Also, it does not apply to issues raised on behalf of enrollees (see the current UMP *Certificate of Coverage* for enrollee appeals procedures). Disputes will be resolved as quickly as possible.

A. The request for a dispute hearing must:
   - Be in writing and signed by the provider requesting the hearing or the provider's representative;
   - State the disputed issue(s);
   - Identify the pertinent contract provision(s);
   - State the provider's position on the issues;
   - Confirm that all other contractually available procedures for resolving the issue have been exhausted;
   - Include the name and address of the provider, as well as the name of any person acting for provider in the matter of the hearing; and
   - Be mailed within 30 days of the date of the letter with the second level decision to:

     Uniform Medical Plan
     (or UMP Neighborhood)
     Provider Dispute Hearing Request
     P.O. Box 91118
     Seattle, WA 98111-9218

B. The UMP Director of Operations may provide a written statement setting forth UMP's position and reasoning, and including any information that may be helpful. Any statement by UMP on the dispute must be mailed to the Administrator and the provider within 20 working days after receipt of the provider's statement.

C. The Administrator shall review the written statements and reply in writing to the provider and UMP Director of Operations within 30 working days. The Administrator may extend this period by notifying all parties.

D. The Administrator may designate someone to act on his or her behalf, following the same procedures and with the same effect as described above.

Both parties to the dispute will continue, without delay, to carry out all respective responsibilities as defined by contract which are not affected by the dispute. Both parties will act in good faith in the dispute resolution and in all matters. Both parties will settle disputes without using this process whenever possible.

8.2 Provider Contract or Network Issues

Inquiries, complaints, or disputes concerning the following issues should be directed to the UMP Provider Services Manager: provider contract provisions, credentialing criteria for network participation, and approved provider types. Correspondence regarding these issues should be sent to:

Uniform Medical Plan
(or UMP Neighborhood)
Provider Services Manager
P.O. Box 91118
Seattle, WA 98111-9218

Appendices

1. Uniform Medical Plan *Certificate of Coverage*
2. *Network Provider Directory*
3. Detail of Remittance (DOR), Inpatient (Example)
4. Detail of Remittance (DOR), Outpatient (Example)
5. UMP Neighborhood information, Including an Example of the *UMP Neighborhood Pass*
6. UMP Neighborhood Explanation of Benefits (EOB) Example
7. UMP Neighborhood Detail of Remittance (DOR) Example

Appendix 3: Detail of Remittance (DOR), Inpatient (Example)

UNIFORM MEDICAL PLAN
PO BOX 34850
SEATTLE WA 98124-1850
Toll Free:1-800-762-6004

HOSPITAL MEDICAL CENTER
PO BOX 999999
SEATTLE WA 98124

SEE LAST PAGE FOR
EXPLANATION OF CODE

PROV#: 111111111
TAX#: 111111111
DATE: 08/08/2004
Draft#: 00297980
ENVOY/NEIC ID#: 75243

PATIENT NAME ACCOUNT #	BENEFIT ID # CLAIM #	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOVD	CODE	DEDUCTIBLE AMOUNT	COPAY COINS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST PERSON	W999999999													
999999999	G9999998-00		04/02/04		0	9,561.00	5,522.78	.00	PPU	.00	600.00	4,038.22	.00	4,922.78
			04/02/04	120	3	3,576.00			*RG					
			04/02/04	250	82	2,584.00			*RG					
			04/02/04	300	2	92.00			*RG					
			04/02/04	301	5	195.00			*RG					
			04/02/04	305	2	152.00			*RG					
			04/02/04	306	6	804.00			*RG					
			04/02/04	307	1	55.00			*RG					
			04/02/04	320	2	504.00			*RG					
			04/02/04	410	6	406.00			*RG					
			04/02/04	450	1	1,058.00			*RG					
			04/02/04	460	1	69.00			*RG					
			04/02/04	942	2	66.00			*RG					
		APDRG		CLAIM TOTAL		9,561.00	5,522.78	.00		.00	600.00	4,038.22	.00	4,922.78
												Payment		4,922.78

Appendix 4: Detail of Remittance (DOR), Outpatient (Example)

UNIFORM MEDICAL PLAN
PO BOX 34850
SEATTLE WA 98124-1850
Toll Free:1-800-762-6004

HOSPITAL MEDICAL CENTER
PO BOX 999999
SEATTLE WA 98124

SEE LAST PAGE FOR
EXPLANATION OF CODE

PROV#: 111111111
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DATE: 08/08/2004
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PATIENT NAME ACCOUNT #	BENEFIT ID # CLAIM #	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOVD	CODE	DEDUCTIBLE AMOUNT	COPAY COINS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST PERSON	W999999999													
999999999	G9999997-00													
			04/02/04	306 87070	1	77.00	77.00	.00		.00	7.70	.00	7.70	69.30
			04/02/04	306 87205	1	48.00	48.00	.00		.00	4.80	.00	4.80	43.20
			04/02/04	450 10060	1	375.00	215.11	.00	Z9 PPU	75.00	14.01	159.89	89.01	126.10
			04/02/04	450 99283	25 1	371.00	303.48	.00	PPU	.00	30.34	67.52	30.34	273.14
		APDRG		CLAIM TOTAL		871.00	643.59	.00		75.00	56.85	227.41	131.85	511.74
													Payment	511.74

UMP Neighborhood

Administered by the Uniform Medical Plan

This supplement provides information and instructions for the UMP Neighborhood Care Systems and other providers outside of the Care Systems who may also treat UMP Neighborhood enrollees. **Billing and claims submittal procedures for services to UMP Neighborhood enrollees are the same whether the provider is or is not affiliated with the enrollee's Care System.** However, higher enrollee cost-sharing applies for most services outside their Care System, with some exceptions.

Section 1: Quick Reference Notes

1.1 Important Addresses and Phone Numbers

Uniform Medical Plan Web site: **www.ump.hca.wa.gov**

UMP Neighborhood Customer and Provider Services

- Benefits information
- Claims status and information
- Enrollee eligibility information*
- General billing questions
- Interactive Voice Response (IVR) system
- Medical review
- Prenotification/preauthorization
- Referral process
- Verify provider's Care System or network status

Automated Enrollee Eligibility Information:

Toll-free: 1-800-335-1062

(Have subscriber I.D. number available, and select #2 for PEBB subscriber information.)

UMP Neighborhood
P.O. Box 34850
Seattle, WA 98124-1850

Toll-free: 1-888-380-2822
Local: 425-686-1218
Fax: 425-670-3199

Case Management Services:

Toll-free: 1-888-759-4855

Electronic Claims Submission

The following clearinghouses frequently submit claims electronically.

Electronic Network Systems (www.enshealth.com)
Toll-free: 1-800-341-6141

WebMD/Envoy (www.WebMD.com)
Toll-free: 1-800-215-4730

ProxyMed (www.proxymed.com)
Toll-free: 1-800-586-6870

Provider Credentialing and Contracting Issues

- Billing manuals and payment policies
- Change of provider status
- Fee schedules
- Network provider applications and contract information
- New provider enrollment
- Policies and procedures
- *Provider Bulletin* feedback

Health Care Authority
Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

Toll-free: 1-800-292-8092
Local: 206-521-2023
Fax: 206-521-2001

Prescription Drugs (retail and mail-order)

- Benefits information
- Claims information
- Cost share information
- Eligibility verification
- Preferred drug list information
- Prior authorization requests
- Network pharmacy information (location and network verification)

Express Scripts, Inc. Member Services:
Toll-free: 1-866-576-3862

Drug Coverage Review and Prior Authorization:
Toll-free: 1-800-417-8164

Fax: 1-877-697-7192

Appeals and Correspondence:

Toll-free: 1-800-417-8164

Fax: 1-877-852-4070

Express Scripts, Inc.
Attn: Pharmacy Appeals: WA5
Mail Route BL0390
6625 West 78th Street
Bloomington, MN 55439

Mail Service Pharmacy (refills):

Toll-free 1-866-576-3862

Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Doctors Network

- Network provider enrollment and contract information
- Billing procedures
- Fee schedule and payment policy information

Alternáre Health Services, Inc.

Toll-free: 1-800-500-0997
Local: 206-405-2923

Tobacco Cessation Services

Free & Clear

Toll-free: 1-800-292-2336

Web Site Information

UMP Neighborhood

www.ump.hca.wa.gov

- UMP *Billing & Administrative Manual* (includes billing and payment policy information for UMP Neighborhood)
- *Certificate of Coverage* (benefits book)
- Care System provider directories
- *Preferred Drug List*
- *Professional Provider Fee Schedule*
- *Anesthesia Fee Schedule*
- *Chiropractor Fee Schedule*
- *Prosthetic and Orthotic Fee Schedule, Including Ostomy and Urological Supplies*
- Other important information

U.S. Preventive Services Task Force Guidelines
www.ahcpr.gov/clinic/uspstf/uspstables.htm

- Preventive care guidelines

Express Scripts, Inc.
www.express-scripts.com

- General prescription drugs information

  Note: See the UMP Web site (**www.ump.hca.wa.gov**) for UMP-specific information for prescription drugs.

Free & Clear
www.freeandclear.org/brochure

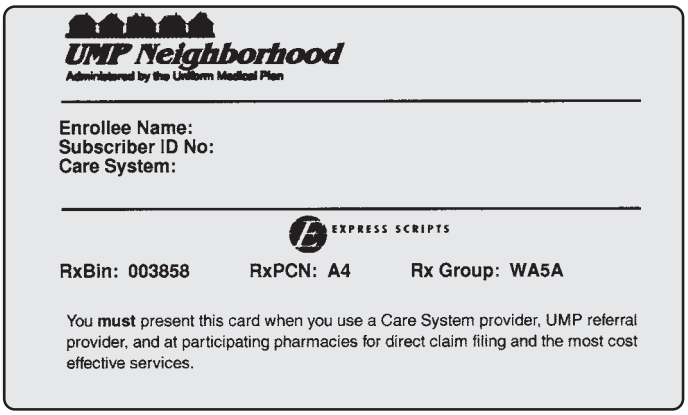
- Tobacco cessation program information

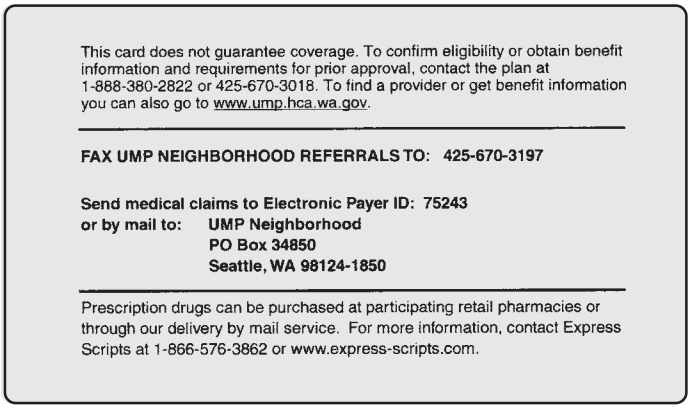
Alternáre Health Services, Inc.
www.alternare.com

- Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Doctors— network provider resources information

1.2 Sample UMP Neighborhood Identification Card

This is the identification card that confirms UMP Neighborhood enrollment. **Please note:** The card also identifies the applicable Care System selected by the enrollee. Except as explained in Section 4.1.3 of this appendix, UMP Neighborhood enrollees receive the highest ("network") level of reimbursement only when they use providers affiliated with the Care System that they selected.





1.3 Claims Submission Information

Paper claims (UB-92 or CMS-1500) should be mailed within 60 days of service (but not beyond 365 days) to the UMP Neighborhood claims office at the following address:

UMP Neighborhood
P.O. Box 34850
Seattle, WA 98124-1850

Claims with missing, inaccurate, or invalid information will be denied or sent back for clarification and resubmission.

Electronic claims submission provides efficiency to your business.

If you are already connected to one of the following clearinghouses that frequently transmits claims electronically, submit your UMP Neighborhood claims to payer I.D. number 75243.

Electronic Network Systems (www.enshealth.com)

Toll-free: 1-800-341-6141

WebMD/Envoy (www.WebMD.com)

Toll-free: 1-800-215-4730

ProxyMed (www.proxymed.com)

Toll-free: 1-800-586-6870

If you are currently submitting paper claims, we encourage you to contact a clearinghouse for information on submitting claims electronically.

1.4 Provider Network Participation

UMP Neighborhood benefits are structured to encourage enrollees to use the services of providers affiliated with the Care System that they selected. As a financial incentive and to promote quality of care, the plan applies considerable cost sharing for enrollees who self-refer to providers who are not in their Care System or on their Care System's panel of referral specialists. There are exceptions for certain provider types (see Section 4.1.3 of this appendix).

Care System providers are expected to refer patients to other providers within their Care System or to specialists who are on their Care System's panel. When it is necessary to refer a UMP Neighborhood patient to a provider who is not affiliated with the patient's Care System, referrals should be to a UMP PPO network provider for services to be reimbursed at the network benefit level. See Section 4.1.3 of this appendix for instructions on notifying our claims administrator of referrals outside the patient's Care System.

The UMP Neighborhood online directory (updated monthly) is available on the Web site at **www.umpneighborhood.com**. You can also view the UMP PPO's online provider directory and network pharmacy directory on the UMP Web site at **www.ump.hca.wa.gov**. A provider's participation can also be confirmed by calling the UMP Neighborhood at 1-888-380-2822 or 425-670-3018. For referral to a Uniform Medical Plan PPO provider, call 1-800-464-0967 or 425-670-3046.

Section 2
Program Outline

2.1 Overview of UMP Neighborhood

UMP Neighborhood is a pilot product administered by the Uniform Medical Plan (UMP) for coverage beginning January 1, 2004. Because this is a pilot, enrollment was offered to a limited number of residents of King, Snohomish, and Pierce counties during the 2004 open enrollment period only. UMP Neighborhood enrollees have the same benefits as those enrolled in the UMP's traditional preferred provider organization (PPO), but they receive care from a more limited choice of network providers. The plan's goals include offering incentives to both providers and enrollees to make cost-effective health care decisions, and providing more affordable plan choices for Public Employees Benefits Board (PEBB) members.

UMP Neighborhood is built upon organized "systems of care" consisting of primary care providers, and a panel of specialists and facilities chosen by the Care System. The primary care providers can only participate in one Care System. Specialists and hospitals may participate in multiple Care Systems.

There are 11 UMP Neighborhood Care Systems participating in 2004. They are identified with their Care System code on the Web site at **www.ump.hca.wa.gov/nhood/** and in the *UMP Neighborhood Provider Directory*. The directory also includes information provided by each of the Care Systems about their program.

Refer to the *UMP Neighborhood Certificate of Coverage* (COC) for deductible, coinsurance, and copayment requirements, as well as for a complete description of plan benefits and scope of coverage. The COC is available on the UMP Web site at **www.ump.hca.wa.gov/nhood/** or by calling 1-888-380-2822.

2.2 Fee Schedule Methodology and Coding Information

Refer to Section 2.2 of the UMP *Billing & Administrative Manual for Professional Providers* for fee schedule, coding, and payment information that are also applicable to UMP Neighborhood. **Please note:** UMP Neighborhood uses the Uniform Medical Plan (UMP) fee schedule(s) for reimbursement of claims. The UMP fee schedules are available on the UMP Web site at **www.ump.hca.wa.gov**.

Section 3
Billing Instructions

Refer to Section 3 of the *Billing & Administrative Manual for Professional Providers* for instructions on completing the CMS-1500 claim form. See Section 7.2.4 of this billing manual for information pertaining to the coordination of benefits process. Samples of the UMP Neighborhood Detail of Remittance (DOR) and Explanation of Benefits (EOB) can be found in Appendices 6 and 7.

Refer to Section 3 of this billing manual for information on completing the UB-92 (CMS-1450) claim form.

Section 4
Provider Information

4.1 Provider Requirements

UMP Neighborhood Care System providers agree to comply with the following requirements.

4.1.1 Credentialing Information

- Maintain applicable licensure, registration, and/or certification.
- Maintain professional liability insurance coverage with limits of liability as determined by the HCA/UMP.
- Meet all other UMP Neighborhood credentialing requirements.
- Submit provider updates following the UMP Adds/Terms/Changes (ATC) submission process provided in Appendix 8 of the UMP *Billing & Administrative Manual for Professional Providers*.
- Accept UMP fee schedules and follow network provider policies and procedures.

4.1.2 Billing Information

Refer to Section 4.1.2 of the UMP *Billing & Administrative Manual for Professional Providers* for billing information that is also applicable to UMP Neighborhood.

4.1.3 Referrals and Authorizations

UMP Neighborhood Care Systems are responsible for managing their panel of providers, including referral specialists. In most cases, UMP Neighborhood enrollees must use the providers in their selected Care System or its panel of referral specialists to obtain the maximum level of benefits. When referring a patient for care outside of their Care System's panel, Care System providers should refer UMP Neighborhood enrollees to a provider within the UMP PPO network unless one is not available for the type of care needed. In addition, the Care System provider should issue a *UMP Neighborhood Pass* when referring the patient outside of his or her Care System's panel. The main purpose of the *UMP Neighborhood Pass* is to notify UMP's claims administrator how to reimburse the claim. With the pass, covered services provided by the UMP PPO network providers are paid at the network benefit level (usually 90 percent of allowed charges, after the enrollee's annual medical/surgical deductible has been met). Covered services provided by providers not in the UMP PPO network are paid at the out-of-network benefit level (usually 80 percent of allowed charges, after the deductible has been met).

Please note that Care System providers do not need to notify our claims administrator of a referral to the following provider types. Enrollees receive network-level benefits when self-referring to any UMP PPO network provider of the following types. Note below some limits on services when self-referring.

- Acupuncturists
- Alcohol/chemical dependency centers and substance abuse treatment facilities
- Ambulatory Surgical Centers
- Audiologists
- Behavioral Health Counselors, including Licensed Mental Health Counselors, Licensed Masters of Social Work, Licensed Marriage and Family Therapists, and Licensed ARNPs with training in psychology and counseling
- Chiropractors
- Community mental health agencies
- Durable medical equipment suppliers
- *Free & Clear* tobacco cessation program
- Free-standing optometry clinics
- Hearing aid fitters and dispensers
- Home health or hospice agencies
- Home infusion providers
- Massage practitioners (requires a written treatment plan from your care system clinician, and must be a UMP PPO network provider)
- Naturopathic physicians
- Optometrists (if outside care system, self-refer only for routine vision services)
- Ophthalmologists (if outside care system, self-refer only for routine vision services)
- Pharmacists
- Pharmacies
- Prosthetic and orthotic suppliers
- Psychologists (licensed)
- Psychiatrists (licensed)
- Skilled nursing facilities
- State mental hospital
- Vision hardware vendors

The following hospital/facility-based physicians who may not be included in the patient's Care System but are necessary for the treatment of the patient will be considered as "in Care System" providers if they are in the UMP PPO provider network:

- Anesthesiologists
- Emergency room physicians
- Radiologists
- Hospitalists
- Pathologists

Finally, the following facilities/suppliers that are generally not selected by the patient are also considered "in Care System" if they are in the UMP PPO provider network:

- Free-standing radiology facilities (including physicians interpreting the x-rays)
- Independent lab facilities

Ambulances and free-standing urgent care facilities will be covered at out-of-network benefit level (usually 80 percent of allowed charges after the enrollee's annual medical/surgical deductible has been met).

A sample of the *UMP Neighborhood Pass* for referrals outside of the Care System is included on the following page. The pass is also available online. The Care System should fax the completed pass to UMP Neighborhood at 425-670-3197, or complete it online and e-mail it through our secure Web site. In addition, the Care System should give a copy of the pass to the patient for the provider to whom they are referred.

4.1.3.1 Self-Referral for Women's Health Care

For covered women's health care services, UMP Neighborhood enrollees will receive network-level benefits when they self-refer to a UMP PPO provider (physician, physician assistant, midwife, or advanced registered nurse practitioner)—regardless of whether the provider is affiliated with their Care System. Women's health care services include:

- Maternity care, reproductive health services, and gynecological care;
- General examinations, preventive care, and medically appropriate follow-up visits for the services previously mentioned or other health services particular to women;
- Appropriate care for other health problems that are discovered and treated during a visit for covered women's health care services.

If a woman self-refers to a non-network provider within Washington State for women's health care services, covered services will be reimbursed at the non-network benefit level.

UMP Neighborhood
Administered by the Uniform Medical Plan

UMP Neighborhood Pass

For _____

For Referrals Outside the Care System

***Please fax to UMP Neighborhood at 425-670-3197, or complete form online and e-mail through our secure Web site at* www.ump.hca.wa.gov.**

Note: This form does not imply coverage of services not covered by UMP Neighborhood, or those requiring preauthorization. See the *UMP Neighborhood Certificate of Coverage* for details.

Provider: Please give the patient a copy of this form. Patient: Give your copy to the provider to whom you are referred.

Patient and Subscriber Information

Patient Name _____ Date of Birth _____

Subscriber Name _____ Subscriber ID # _____

Patient Home Phone _____

Provider To Whom Referral is Being Made

Referred To

_____ Provider (Last, First)

_____ Type of Provider (such as M.D. or D.O.)

_____ Street Address

_____ Specialty

_____ City/State/ZIP Code

_____ Phone Number

Reason for Referral and Referring Provider

Diagnosis _____ ICD-9 Code _____ Date of Referral _____

Reason for referral _____

_____

Expected length of treatment _____

Referral requested for ☐ Consultation ☐ Consultation/Test/Treatment ☐ All Services

Referred By

_____ Print Provider Name

_____ Provider Address

_____ Provider Signature

_____ City/State/ZIP Code

_____ Phone Number

_____ Fax Number

Section 5
Enrollee Responsibilities

5.1 Enrollee Requirements

UMP Neighborhood enrollees should seek all medical care through providers within the Care System as identified on their I.D. card, except for providers/facilities that they can self-refer to as previously indicated in Section 4.1.3 of this appendix. If they seek medical care outside of the Care System without a *UMP Neighborhood Pass* where it is required, payment for covered services will be at the UMP non-network benefit level (generally 60 percent of allowed charges, after the enrollee's annual medical/surgical deductible has been met).

Subscriber education is an important factor in ensuring the timely and appropriate payment of health care benefits. When seeking health care, UMP Neighborhood enrollees have the responsibility to:

- Use their UMP Neighborhood Care System and network providers when available to help ensure quality care at the lowest cost.
- Identify themselves as a UMP Neighborhood enrollee when calling for an appointment.
- Present their identification card at the time services are rendered.
- Understand UMP Neighborhood benefits, including what's covered, preauthorization and review requirements, and other information described in the *Certificate of Coverage*.

UMP Neighborhood enrollees may change to a different Care System during the plan year with at least 30 days' notice. If the new Care System is accepting new patients, coverage is effective the first of the month following the 30 days' notice. In these circumstances, UMP Neighborhood will issue a new I.D. card to the patient to reflect the change to a different Care System.

If your patients have questions regarding UMP Neighborhood benefits, network provider status, or payment of their claims, please refer them to:

UMP Neighborhood Customer Service

Toll-free: 1-888-380-2822

Local: 425-686-1218

Section 6
Utilization Review Requirements

Refer to Section 6 of this billing manual for preauthorization and utilization review requirements, including review criteria and case management information also applicable to UMP Neighborhood. Care System providers are encouraged to contact case management on all catastrophic cases.

Section 7
Payment Rules

7.1 General Information

7.1.1 UMP Neighborhood *Certificate of Coverage*

The UMP Neighborhood *Certificate of Coverage* (COC) (available on the UMP Web site at **www.ump.hca.wa.gov** or by calling 1-888-380-2822) is the official source of plan benefits and scope of coverage information. Providers must rely on the COC to obtain full and complete information regarding the scope of coverage and benefit provisions of UMP Neighborhood.

7.1.2 Plan Payment Provisions for Providers

Unless otherwise specified in the COC, the applicable calendar year deductible must be satisfied before UMP Neighborhood will make a payment for services provided under a given benefit.

Services exempt from the annual medical/surgical deductible include:

- Preventive care*;
- Retail and mail-order prescription drugs**;
- Routine vision exams and hardware;
- Required second surgical opinions; and
- Tobacco cessation services provided through the *Free & Clear* smoking cessation program.

*UMP Neighborhood follows the preventive care guidelines established by the U.S. Preventive Services Task Force (USPSTF) when determining coverage for preventive care. See Section 7.2.2, Preventive Care, in the *UMP Billing & Administrative Manual for Professional Providers* for more information.

**The UMP Neighborhood has a separate annual deductible for prescription drugs. It is a combined retail and mail-order deductible. See the UMP Neighborhood *Certificate of Coverage* for more details.

After the enrollee's annual medical/surgical deductible has been met, the plan's payment provisions generally are as follows:

- For covered services from **providers affiliated with the enrollee's Care System, or from providers of the types listed in Section 4.1.3 of this appendix who are contracted with UMP PPO,** the plan pays 90 percent of the allowable amount. (The "allowable amount" is the actual charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent.
- For covered services from **other providers**, the plan pays:
  - 90 percent of the allowable amount when a *UMP Neighborhood Pass* has been issued and the provider is a UMP PPO network

provider. (The "allowable amount" is the actual charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent.

- 80 percent of the allowable amount when a *UMP Neighborhood Pass* has been issued and the provider is not a UMP PPO network provider. (The "allowable amount" is the actual charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 20 percent plus the difference between the allowed amount and the billed charges.
- 60 percent of the allowable amount when a *UMP Neighborhood Pass* has not been issued, regardless of whether the provider is a UMP PPO network provider or is participating as a UMP Neighborhood provider with a different Care System. (The "allowable amount" is the actual charge or the fee schedule amount, whichever is less.) In this circumstance, the enrollee is responsible for the remaining 40 percent if the provider is a UMP PPO network provider. A UMP PPO network provider cannot bill the enrollee for the difference between the billed and allowed charge. If the provider is not a UMP PPO network provider, the enrollee is responsible for the remaining 40 percent plus the difference between the allowed amount and the billed charges.

For all providers (Care System, UMP PPO, out-of-network, and non-network), the UMP fee schedules and payment policies determine the allowed charges used for UMP Neighborhood reimbursement. These fee schedules and the UMP billing manual are available on the UMP Web site at **www.ump.hca.wa.gov**. Note that a payment differential applies to payments for certain categories of providers. This differential is described in Section 7.1.3 of the *UMP Billing & Administrative Manual for Professional Providers*.

In referral situations where a *UMP Neighborhood Pass* is not required as indicated in Section 4.1.3 of this appendix, UMP Neighborhood payment is based on the network or non-network status of the provider and the applicable benefit.

Emergency care from non-network or out-of-area providers is based on 80% of allowed charges.

Non-urgent, non-emergent care outside of Washington State is not covered, unless referred by a Care System provider.

For details regarding UMP Neighborhood enrollee benefits and scope of coverage, see the UMP Neighborhood *Certificate of Coverage*. As explained in that document, UMP Neighborhood enrollees have an annual out-of-pocket limit, as well as some benefit limits. When benefits are paid as network or "out-of-network" (generally used to refer to situations when the enrollee did not have access to network services, as determined by UMP), the enrollee's coinsurance and copayments count towards his or her annual out-of-pocket limit. "Non-network" services (used to refer to all other situations, when the enrollee had access to

network services but did not use them) are not counted towards the enrollee's out-of-pocket limit. Once the enrollee's out-of-pocket limit is reached, most network and out-of-network services will be paid at 100 percent for the remainder of that calendar year. Specific benefit limits, however, still apply.

Note: Services rendered under private contracts by providers who "opt out" of the Medicare program will not be covered or reimbursed by UMP Neighborhood. Exceptions are services provided on an emergency/urgent basis or that are excluded under the Medicare program, such as routine eye exams and certain preventive care services/procedures, which will be processed and paid according to UMP Neighborhood benefits. In a private contract situation, the enrollee is solely responsible for the provider's total billed charges.

Section 8:
Provider Inquiries, Complaints, Reconsideration Procedures, and Dispute Resolutions

Refer to Section 8 of this billing manual for procedures for inquiries, complaints, claims reconsideration requests, and dispute resolutions that are also applicable to UMP Neighborhood.

Appendix 6: UMP Neighborhood Explanation of Benefits (EOB) Example

UMP Neighborhood
Administered by the Uniform Medical Plan

UMP NEIGHBORHOOD
PO BOX 34850
SEATTLE WA 98124-1850

A BENEFIT PROGRAM FOR EMPLOYEES OF WASHINGTON STATE

Important: Keep this for your permanent records and tax purposes

For questions or review of the decision, please write:
UMP NEIGHBORHOOD
P O BOX 34850
SEATTLE WA 98124-1850

For questions or review of the decision, please phone:
1-888-380-2822 Toll Free

TEST
19401 40th AVE. W Ste 200
Lynnwood, WA 98036

Employee: TEST
Patient: TEST
Relationship: EMPLOYEE
Member ID: 999999999
Patient Acct No: 01
Provider No: 999999999
Claim No: TEST CLAIM-00
Date: 01/10/2004

EXPLANATION OF BENEFITS

Provider/Date(s) of Service	Proc. Code	Billed Charge	Non Covered Amount	Message Code	PPO Savings	Allowed Amount	Applied to Deductible	Balance	Pct %	Total
PHYSICIAN MD 03/20/04 - 03/20/04	99213	75.00		PPU	9.63	65.32		65.32	90	58.79
PHYSICIAN MD 03/20/04 - 03/20/04	74000	60.00		PPU	16.93	43.07		43.07	90	38.76
TOTALS		135.00			26.56	108.39	0.00	108.39		97.55
									Less Adjustments:	0.00
									Total:	97.55

Employee Responsibility **10.84** **Other Insurance Paid** **0.00**

Messages

THANK YOU FOR USING A UMP NEIGHBORHOOD
PARTICIPATING PROVIDER
PPU THIS IS YOUR PLAN'S NETWORK CONTRACTUAL ALLOWANCE FOR THIS SERVICE.
PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.

Accumulators

YOU HAVE MET 200.00 OF YOUR 200.00 DEDUCTIBLE FOR 01/01/2004 - 12/31/2004

Appendix 7: UMP Neighborhood Detail of Remittance (DOR) Example

UMP NEIGHBOR HOOD
P O BOX 34850
SEATTLE WA 98124-1850
Toll Free: 1-888-380-2822

DOCTORS CLINIC
PO BOX 999
SEATTLE WA 98124

PHYSICIAN MD

SEE LAST PAGE FOR
EXPLANATION OF CODE

PROV#: 9999999900
TAX#: 9999999999
DATE: 05/02/2004
Draft #: 0000000
ENVOY/NEIC ID#: 000000000

PATIENT NAME ACCOUNT #	BENEFIT ID # CLAIM #	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOV'D	CODE	DEDUCTIBLE AMOUNT	COPAY COINS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST	999999999													
C999999	TEST CLAIM-00		03/20/04	99213	1	75.00	65.32	.00	PPU	.00	6.53	9.63	6.53	58.79
			03/20/04	72040	1	60.00	43.07	.00	PPU	.00	4.31	16.93	4.31	38.76
		APDRG		**CLAIM TOTAL**		**135.00**	**108.39**		**.00**		**.00**	**10.84**	**26.56**	**10.84**
													Pavment	97.55

TOTAL PAID 97.55

Code Descriptions

****
PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.
****

PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.

******* REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED, TO INCLUDE BUNDLING, COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO: UNIFORM MEDICAL PLAN, P.O. BOX 34578, SEATTLE, WA 98125-1578